

1 Common Program Requirements
2 Sleep Medicine

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4 Preface

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6 The program requirements set forth here are to be considered common to all
7 specialties, and are complete only when supplemented, where indicated and
8 individually, by each specialty.
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10 **I. Introduction**

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12 **A. Definition and Scope of the Specialty**

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14 Sleep medicine is a discipline of medical practice in which sleep disorders
15 are assessed, monitored, treated, and prevented by using a combination
16 of techniques (clinical evaluation, physiologic testing, imaging, and
17 intervention) and medication. Specialists in sleep medicine are expected
18 to:

- 19
20 1. participate in an interdisciplinary care of patients of all ages that
21 incorporates aspects of psychiatry, neurology, internal medicine,
22 epidemiology, surgery, pediatrics and basic science;
23
24 2. acquire detailed knowledge of the sleep and respiratory control
25 centers, aphysiology, and neurobiology underlying sleep and
26 wakefulness;
27
28 3. diagnose and manage sleep disorder patients in outpatient and
29 inpatient settings.
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31 **II. Institutions**

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33 **A. Sponsoring Institution**

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35 **One sponsoring institution must assume ultimate responsibility for**
36 **the program, as described in the Institutional Requirements, and this**
37 **responsibility extends to fellow assignments at all participating**
38 **institutions.**

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40 **B. Participating Institutions**

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42 1. **Assignment to an institution must be based on a clear**
43 **educational rationale, integral to the program curriculum, with**
44 **clearly-stated activities and objectives. When multiple**
45 **participating institutions are used, there should be assurance**
46 **of the continuity of the educational experience.**

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- 2. **Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:**
 - a) **identity the faculty who will assume both educational and supervisory responsibilities for fellows;**
 - b) **specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document;**
 - c) **specify the duration and content of the educational experience; and**
 - d) **state the policies and procedures that will govern fellow education during the assignment.**

III. Program Personnel and Resources

A. Program Director

- 1. **There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the RRC through the Web Accreditation Data System of the ACGME.**
- 2. **The Program Director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership.**
- 3. **Qualifications of the program director are as follows:**
 - a) **The program director must possess the requisite specialty expertise, as well as documented educational and administrative abilities.**
 - b) **The program director must be Board-certified in Internal Medicine, Pulmonology, Psychiatry, Pediatrics, Neurology, or Otolaryngology, and be certified by the applicable ABMS**

93 **board in sleep medicine or possess qualifications judged**
94 **to be acceptable by the sponsoring RRC.**

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96 **c) The program director must be appointed in good**
97 **standing and based at the primary teaching site.**

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99 d) The program director must be fully committed to the
100 fellowship program, and devote sufficient time to provide
101 leadership and supervision to the program and its fellows.
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103 **4. Responsibilities of the program director are as follows:**

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105 **a) The program director must oversee and organize the**
106 **activities of the educational program in all institutions**
107 **that participate in the program. This includes selecting**
108 **and supervising the faculty and other program**
109 **personnel at each participating institution, appointing a**
110 **local site director, and monitoring appropriate fellow**
111 **supervision at all participating institutions.**

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113 **b) The program director is responsible for preparing an**
114 **accurate statistical and narrative description of the**
115 **program as requested by the RRC, as well as updating**
116 **annually both program and fellow records through the**
117 **ACGME's Accreditation Data System.**

118
119 **c) The program director must ensure the implementation**
120 **of fair policies, grievance procedures, and due process,**
121 **as established by the sponsoring institution and in**
122 **compliance with the Institutional Requirements.**

123
124 **d) The program director must seek the prior approval of**
125 **the RRC for any changes in the program that may**
126 **significantly alter the educational experience of the**
127 **fellows. Such changes, for example, include:**

128
129 **(1) the addition or deletion of a participating**
130 **institution;**

131
132 **(2) a change in the format of the educational**
133 **program;**

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135 **(3) a change in the approved fellow complement for**
136 **those specialties that approve fellow-complement.**
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138 On review of a proposal for any such major change in a
139 program, the RRC may determine that a site visit is
140 necessary.
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142 **B. Faculty**
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144 1. **At each participating institution, there must be a sufficient**
145 **number of faculty with documented qualifications to instruct**
146 **and supervise adequately all fellows in the program.**
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148 2. **The faculty, furthermore, must devote sufficient time to the**
149 **educational program to fulfill their supervisory and teaching**
150 **responsibilities. They must demonstrate a strong interest in**
151 **the education of fellows, and must support the goals and**
152 **objectives of the educational program of which they are a**
153 **member.**
154

155 Appropriate expertise in the areas defined above in Section I must
156 be present between the Director and faculty. The RRC recognizes
157 that expertise in sleep medicine is available from physicians who
158 are Board certified in many medical specialties, particularly in
159 Internal Medicine, Pulmonology, Psychiatry, Pediatrics, Neurology,
160 and Otolaryngology. The RRC encourages multidisciplinary
161 cooperation in educating fellows.
162

163 3. **Qualifications of the physician faculty are as follows:**
164

165 a) **The physician faculty must possess the requisite**
166 **specialty expertise and competence in clinical care and**
167 **teaching abilities, as well as documented educational**
168 **and administrative abilities and experience in their field.**
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170 b) **The physician faculty must be Board-certified** in Internal
171 **Medicine, Pulmonology, Psychiatry, Pediatrics, Neurology,**
172 **or Otolaryngology, and be certified by the applicable ABMS**
173 **board in sleep medicine or possess qualifications judged**
174 **to be acceptable by the RRC.**
175

176 c) The physician faculty must be appointed in good standing to
177 the staff of an institution participating in the program.
178

179 4. **The responsibility for establishing and maintaining an**
180 **environment of inquiry and scholarship rests with the faculty,**
181 **and an active research component must be included in each**
182 **program. *Scholarship* is defined as the following:**
183

- 184 a) the scholarship of *discovery*, as evidenced by peer-
185 reviewed funding or by publication of original research
186 in a peer-reviewed journal;
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188 b) the scholarship of *dissemination*, as evidenced by
189 review articles or chapters in textbooks;
190
191 c) the scholarship of *application*, as evidenced by the
192 publication or presentation of, for example, case reports
193 or clinical series at local, regional, or national
194 professional and scientific society meetings.
195

196 Complementary to the above scholarship is the regular
197 participation of the teaching staff in clinical discussions,
198 rounds, journal clubs, and research conferences in a manner
199 that promotes a spirit of inquiry and scholarship (e.g., the
200 offering of guidance and technical support for fellows involved
201 in research such as research design and statistical analysis);
202 and the provision of support for fellows' participation, as
203 appropriate, in scholarly activities.
204

205 5. Qualifications of the nonphysician faculty are as follows:
206

- 207 a) Nonphysician faculty must be appropriately qualified in
208 their field.
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210 b) Nonphysician faculty must possess appropriate
211 institutional appointments.
212

213 6. Other Program Personnel
214

215 Additional necessary professional, technical, and clerical
216 personnel must be provided to support the program.
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218 7. Resources
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220 The program must ensure that adequate resources (e.g.,
221 sufficient laboratory space and equipment, computer and
222 statistical consultation services) are available.
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224 IV. Fellow Appointments
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226 A. Eligibility Criteria
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228 The program director must comply with the criteria for fellow
229 eligibility as specified in the Institutional Requirements.

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B. Number of Fellows

The program will approve the number of fellows based upon established written criteria that include the adequacy of resources for fellow education (e.g., the quality and volume of patients and related clinical material available for education), faculty-fellow ratio, institutional funding, and the quality of faculty teaching.

C. Fellow Transfers

To determine the appropriate level of education for fellows who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring fellow prior to their acceptance into the program. A program director is required to provide verification of residency education for fellows who may leave the program prior to completion of their education.

D. Appointment of Fellows and Other Students

The appointment of fellows, other specialty residents, or students must not dilute or detract from the educational opportunities available to regularly appointed fellows.

V. Program Curriculum

A. Program Design

1. Format

The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.

2. Goals and Objectives

The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of fellows for each major assignment and for each level of the program. This statement must be distributed to fellows and faculty, and must be reviewed with fellows prior to their assignments.

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B. Specialty Curriculum

The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide fellows with direct experience in progressive responsibility for patient management.

C. Fellows Scholarly Activities

Each program must provide an opportunity for fellows to participate in research or other scholarly activities, and fellows must participate actively in such scholarly activities.

D. ACGME General Competencies

The program must require its fellows to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their fellows to demonstrate the following:

1. ***Patient care*** that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health;
2. ***Medical knowledge*** about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;
3. ***Practice-based learning and improvement*** that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements inpatient care;
4. ***Interpersonal and communication skills*** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals.
5. ***Professionalism***, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;
6. ***Systems-based practice***, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide

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VI. Fellow Duty Hours and the Working Environment

Providing fellows with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and fellow well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on fellows to fulfill service obligations. Didactic and clinical education must have priority in the allotment of fellows' time and energy. Duty hour assignments must recognize that faculty and fellows collectively have responsibility for the safety and welfare of patients.

A. Supervision of Fellows

- 1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of fellows at all times. Fellows must be provided with rapid, reliable systems for communicating with supervising faculty.**
- 2. Faculty schedules must be structured to provide fellows with continuous supervision and consultation.**
- 3. Faculty and fellows must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.**

B. Duty Hours

- 1. Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.**
- 2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
- 3. Fellows must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.**

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- 4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

C. On-call Activities

The objective of on-call activities is to provide fellows with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work day, when fellows are required to be immediately available in the assigned institution.

- 1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.
- 2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Fellows may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.
- 3. No new patients may be accepted after 24 hours of continuous duty.
- 4. At-home call (or pager call) is defined as a call taken from outside the assigned institution.
 - a) The frequency of at-home call is not subject to the every-third- night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each fellow. Fellows taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
 - b) When fellows are called into the hospital from home, the hours fellows spend in-house are counted toward the 80-hour limit.
 - c) The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

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D. Moonlighting

1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.
2. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.
3. Any hours a fellow works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of internal moonlighting.

E. Oversight

1. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for fellow duty hours and the working environment. These policies must be distributed to the fellows and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.
2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create fellow fatigue sufficient to jeopardize patient care.

F. Duty Hours Exceptions

An RRC may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. Prior permission of the institution's GMEC, however, is required.

VII. Evaluation

A. Fellow

1. Formative Evaluation

The faculty must evaluate in a timely manner the fellows whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing

458 fellow performance throughout the program, and for utilizing
459 the results to improve fellow performance.

- 460
- 461 a) Assessment should include the use of methods that
462 produce an accurate assessment of fellows'
463 competence in patient care, medical knowledge,
464 practice-based learning and improvement, interpersonal
465 and communication skills, professionalism, and
466 systems-based practice.
- 467
- 468 b) Assessment should include the regular and timely
469 performance feedback to fellows that includes at least
470 semiannual written evaluations. Such evaluations are to
471 be communicated to each fellow in a timely manner, and
472 maintained in a record that is accessible to each fellow.
- 473
- 474 c) Assessment should include the use of assessment
475 results, including evaluation by faculty, patients, peers,
476 self, and other professional staff, to achieve progressive
477 improvements in fellows' competence and performance.
- 478
- 479 d) Assessments by a faculty member must occur at least once
480 every two months. Such evaluations are to be
481 communicated to each fellow in a timely manner.

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483 **2. Final Evaluation**

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485 The program director must provide a final evaluation for each
486 fellow who completes the program. This evaluation must
487 include a review of the fellow's performance during the final
488 period of education, and should verify that the fellow has
489 demonstrated sufficient professional ability to practice
490 competently and independently. The final evaluation must be
491 part of the fellow's permanent record maintained by the
492 institution.

493

494 **B. Faculty**

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496 The performance of the faculty must be evaluated by the program no
497 less frequently than at the midpoint of the accreditation cycle, and
498 again prior to the next site visit. The evaluations should include a
499 review of their teaching abilities, commitment to the educational
500 program, clinical knowledge, and scholarly activities. This evaluation
501 must include annual written confidential evaluations by fellows.

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C. Program

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

1. Representative program personnel (i.e., at least the program director, representative faculty, and one fellow) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the fellows' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.
2. The program should use fellow performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.

VIII. Experimentation and Innovation

Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in advance by the RRC, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of education offered to fellows for the duration of such a project.

IX. Certification

Fellows who plan to seek certification by Board should communicate with office of the specific specialty board regarding the full requirements for certification.

547 **Program Requirements for Fellowship Education in Sleep Medicine**

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549 **X. Educational Program**

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551 A. A subspecialty educational program in sleep medicine must be organized
552 to provide educational and supervised experience at a level sufficient for
553 the fellow to acquire competence in the field.

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555 B. The educational program must be 1 year in duration.

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557 1. At least 12 months of the program must be devoted to the inpatient
558 and ambulatory clinical experiences.

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560 2. Education must be separate and distinct from all education required
561 for certification in the core sponsoring specialties and in pulmonary
562 disease.

563

564 C. All applicants entering the sleep medicine residency must have completed
565 a core educational program accredited by the ACGME in a sponsoring
566 specialty. The sponsoring specialties are family medicine, internal
567 medicine, neurology, otolaryngology, pediatrics, and psychiatry.

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569 D. A sponsoring institution may have only one accredited sleep medicine
570 program.

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572 E. The sponsoring specialty (internal medicine, neurology, otolaryngology,
573 pediatrics, or psychiatry) must have a core education program accredited
574 by the ACGME.

575

576 **XI. Faculty**

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578 There must be a minimum of 2 core clinical faculty members, including the
579 Program Director. In programs with more than 4 fellows, a ratio of one core
580 clinical faculty to every 2 fellows must be maintained.

581

582 **XII. Facilities and Resources**

583

584 A. Patient Population

585

586 1. There must be an adequate number and variety of patients of all
587 ages in both inpatient and outpatient settings to expose fellows to
588 the broad spectrum of sleep disorders.

589

590 a) Experience should include evaluation of hospitalized sleep
591 disorder patients. Fellows should make regular patient
592 management rounds and record reviews with the attending

- 593 faculty.
- 594
- 595 b) Experience should include longitudinal management of
- 596 patients for whom the fellow is the primary physician (but
- 597 acting under the supervision of a faculty member).
- 598
- 599 c) The patients seen by fellows must have a balance of age,
- 600 gender, and short- and long-term disorders.
- 601
- 602 2. The patient population should include patients with the major
- 603 categories of sleep disorders, including:
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- 605 a) apnea and other sleep-related breathing disorders;
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- 607 b) parasomnias;
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- 609 c) circadian rhythm disorders;
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- 611 d) insomnia;
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- 613 e) narcolepsy and related excessive daytime sleepiness
- 614 disorders; and
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- 616 f) sleep problems related to other factors and diseases such as
- 617 medications, and psychiatric and medical disorders.

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619 **B. Facilities**

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- 621 1. The sleep laboratory facility should be appropriately equipped, and
- 622 have a minimum of 2 fully-equipped polysomnography bedrooms
- 623 and support space. The American Academy of Sleep Medicine or
- 624 an equivalent body should accredit the sleep laboratories and other
- 625 related facilities and equipment for the use of both adults and
- 626 children.
- 627
- 628 2. There must be adequate space and equipment for the educational
- 629 program, including meeting rooms, classrooms with audiovisual
- 630 and other educational aids, office space for staff and fellows,
- 631 pertinent library materials, and diagnostic, therapeutic, and
- 632 research facilities.
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634 **XIII. Specific Program Content**

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636 **A. Clinical Experience**

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- 638 1. Fellows must have formal instruction, clinical experience, and

- 639 demonstrated competence in the following:
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641 a) performing competent physical, neurological, and mental
642 status examinations, and recording the findings completely
643 and systematically;
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645 b) integrating information obtained from patient history, physical
646 examination, physiologic recordings, imaging studies,
647 psychometric testing, pulmonary function testing, and
648 biochemical and molecular tests results to arrive at an
649 accurate and timely diagnosis and treatment plan;
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651 c) diagnosing medical and psychiatric sleep disorders, as well
652 as sleep disorders associated with common medical,
653 neurologic, and psychiatric conditions;
654
655 d) formulating appropriate treatment plans and making
656 appropriate referrals; and
657
658 e) observing, evaluating, and managing patients of all ages
659 with a wide variety of sleep disorders.
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- 661 2. Fellows must have formal instruction and clinical experience in:
662
663 a) systems-based skills that include working in outpatient and
664 inpatient settings and effectively utilizing health care
665 resources; and
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667 b) the administration of sleep disorders center, especially
668 leadership of interdisciplinary teams.
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- 670 3. Fellows should have clinical experiences that provide for basic and
671 advanced education, as well as professional development,
672 including:
673
674 a) opportunities to formulate a clinical diagnosis and to order
675 and use laboratory data to clinically evaluate a patient's
676 condition and to support outpatient and inpatient diagnostic
677 evaluations;
678
679 b) progressive experience for education that includes caring for
680 a sufficient number of sleep disorder patients to achieve
681 competence in the assessment of patients with a wide range
682 of sleep medicine disorders;
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- 684 c) experience with medical, neurologic, and psychiatric
685 disorders displaying symptoms likely to be related to sleep
686 disorders (e.g., the relationship between hypertension and
687 snoring);
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689 d) experience with the interactions between treatment for sleep
690 disorders and other medical, neurologic, and psychiatric
691 treatment;
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693 e) experience and/or familiarity with the major types of therapy,
694 including psychotherapy, pharmacotherapy, surgical
695 treatment, behavioral treatments, and other somatic
696 therapies;
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698 f) clinical consults and teaching from the following disciplines
699 as related to sleep disorders: cardiology, neurology,
700 otolaryngology, oral maxillofacial surgery, pediatrics,
701 pulmonary medicine, psychiatry, and psychology including
702 neuropsychology, pathology, and radiology services; and
703
704 g) supervised experience in teaching sleep medicine to
705 students in the health professions.
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707 It is suggested that the above experiences are attained by multidisciplinary
708 cooperation in the diagnosis and treatment of sleep patients.
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710 B. Technical and Other Skills

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712 1. Fellows must have formal instruction, clinical experience, and
713 demonstrated competence at the completion of education in the
714 following:
715
716 a) the indications for and potential pitfalls and limitations of
717 diagnostic tests and the interpretation of the results in the
718 context of the clinical situation. These diagnostic tests must
719 include the following:
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721 (1) polysomnography, scoring and interpretation of
722 polysomnograms and recognition of artifacts,
723 including montages with additional EEG leads for
724 seizure detection;
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726 (2) multiple sleep latency testing;
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728 (3) maintenance of wakefulness testing;
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- 730 (4) actigraphy;
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732 (5) portable monitoring related to sleep disorders;
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734 (6) imaging studies, magnetic resonance imaging; and
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736 (7) psychological and psychometric tests as they relate to
737 sleep disorders.
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739 b) skills necessary to perform polysomnographies from
740 preparation and hookup of the patient to the completion of
741 the study, including multiple sleep latency and maintenance
742 of wakefulness tests;
743
744 c) scoring and interpretation of polysomnograms and
745 recognition of artifacts, including full montages with
746 additional EEG leads for seizure detection;
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748 d) consultative skills in sleep medicine in a variety of medical,
749 surgical, and psychiatric settings;
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751 e) certification in cardiopulmonary resuscitation; and
752
753 f) relating to patients and their families, as well as other
754 members of the health care team, with compassion, respect,
755 and professional integrity.
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757 C. Formal Instruction
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- 759 1. The education program must conduct a monthly, multidisciplinary
760 teaching conference and a monthly journal club organized by the
761 faculty on topics that cover the scope of sleep medicine.
762
763 2. The education program must conduct seminars and core
764 conferences. This instruction must be relevant for pediatric and
765 adult patients.
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767 3. Fellows must have formal instruction in, and demonstrate
768 comprehensive knowledge of:
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770 a) fundamental mechanisms of sleep, major theories in sleep
771 medicine, and the generally-accepted facts of basic sleep
772 mechanisms:
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774 (1) Basic neurological sleep mechanisms;
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- 776 (2) Chronobiological mechanisms;
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778 (3) Respiratory physiology during sleep and
779 pathophysiology;
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781 (4) Cardiovascular physiology during sleep and
782 pathophysiology;
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784 (5) Endocrine physiology during sleep and
785 pathophysiology;
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787 (6) Gastrointestinal physiology during sleep and
788 pathophysiology;
789
790 (7) Ontogeny of sleep; and
791
792 (8) Sleep across the life span.
793
794 b) airway anatomy;
795
796 c) nosology for sleep disorders: *The International Classification*
797 *of Sleep Disorders*;
798
799 d) etiopathogenic characterization of sleep disorders;
800
801 e) pharmacology of sleep (i.e. medication effects on sleep);
802
803 f) clinical manifestations of sleep disorders:
804
805 (1) evaluation of patients presenting with excessive
806 sleepiness;
807
808 (2) evaluation of patients presenting with difficulty
809 initiating or maintaining sleep;
810
811 (3) evaluation of patients presenting with parasomnias;
812
813 (4) biological rhythm disorders;
814
815 (5) pediatric and neonatal sleep medicine;
816
817 (6) SIDs and related respiratory distress;
818
819 (7) medical, neurologic, and psychiatric disorders
820 displaying symptoms likely to be related to sleep
821 disorders (e.g., the relationship between hypertension

- 822 and snoring);
- 823
- 824 (8) Biological, psychological, social, economic, ethnic,
- 825 and familial factors which significantly influence the
- 826 evaluation and treatment of sleep disorders; and
- 827
- 828 (9) The nature of the interactions between treatment for
- 829 sleep disorders and other medical, neurologic, and
- 830 psychiatric treatment.
- 831
- 832 g) diagnostic strategies in sleep disorders:
- 833
- 834 (1) etiologies, prevalence, diagnosis, and treatment of all
- 835 of the sleep disorders in the current nosology of sleep
- 836 medicine;
- 837
- 838 (2) the use, reliability, and validity of the generally-
- 839 accepted techniques for diagnostic assessment; and
- 840
- 841 (3) administration and interpretation of psychological
- 842 tests.
- 843
- 844 h) treatment strategies in sleep disorders:
- 845
- 846 (1) treatment approaches for obstructive sleep apnea, to
- 847 include nasal CPAP, bilevel PAP, upper airway
- 848 surgery, oral appliances, and position education;
- 849
- 850 (2) treatment approaches for insomnia, to include
- 851 cognitive-behavioral therapies and pharmacological
- 852 therapy;
- 853
- 854 (3) treatment approaches for narcolepsy and idiopathic
- 855 CNS hypersomnolence;
- 856
- 857 (4) treatment approaches for parasomnias; and
- 858
- 859 (5) treatment of circadian rhythm disorders.
- 860
- 861 i) operation of polysomnographic monitoring equipment:
- 862
- 863 (1) polysomnographic troubleshooting;
- 864
- 865 (2) ambulatory monitoring methodology; and
- 866
- 867 (3) polysomnogram interpretation.

- 868
- 869 j) financing and regulation of sleep medicine;
- 870
- 871 k) medical ethics and its application in sleep medicine;
- 872
- 873 l) legal aspects of sleep medicine; and
- 874
- 875 m) epidemiological issues:
- 876
- 877 (1) research methods in the clinical and basic sciences
- 878 related to sleep medicine; and
- 879
- 880 (2) critically appraising the professional and scientific
- 881 literature, and applying new contributions to
- 882 management and care of patients.
- 883

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885 ACGME Approved: June 2004 Effective: June 2004

886 Editorial Revisions: April 2005

887 Editorial Revisions: June 2005

888 ACGME-Approved Minor Revision: February 12, 2008 Effective: April 12, 2008